Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
A American Homecare

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-15-0578-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am preparing this letter due to an unresolved payment. Attached you will find where half of the claim was paid on 10/20/2014, however PT visits were not. Please advise we would like to get this account resolved."

Amount in Dispute: $5,440.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent respectfully submits that to date HCP has failed to submit proof of timely filing of a complete submission and therefore the initial denial was appropriate and in accordance with Texas Administrative Code."

Response Submitted by: CorVel Corporation, 3520 Executive Center Drive, Suite 300, Austin, TX 78731

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 16 through December 24, 2013	G0151, G0154	$5,440.00	$356.55

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for home health services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Svc lacks info needed or has billing error(s)
   - 29 – Time limit for Filing Claim/Bill has expired
   - RW2 – Code not found in Medicaid FS

Issues

1. Did the requestor submit evidence of timely filing?
2. What is the applicable rule that determines reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 29 – "Time limit for Filing Claim/Bill has expired". Per 28 Texas Administrative Code §133.20 (b) "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Review of the submitted documentation finds;
    a. Copy of UB-04 with creation date February 21, 2014
    b. Stamp from March 20, 2014 showing received
    c. Per Rule 133.20 dates of service November 16, 2013 through December 13, 2013 are past the timely filing limit and will not be considered in this review.
    d. Dates of service December 18 – 24, 2013 are eligible for review and will be considered based on applicable rules and fee guidelines
2. Per 28 Texas Administrative Code §134.204 (f) "To determine the MAR amount for home health services provided through a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies." Review of the TMHP web site, http://public.tmhp.com/FeeSchedules/OnlineFeeLookup/FeeScheduleSearchResults.aspx finds; the allowable for G0154 is $98.92 per unit. The allowable for G0151 under Medicaid CSHC program is $11.41 per unit. The dates of service eligible for review will be calculated as follows;

Date of Service	Submitted Code	Charge	Units	MAR 125% of Medicaid Fee Schedule	Carrier Paid	Amount due
12/18/13	G0151	$170.00	5	$11.41 x 125% = $14.26 x 5 = $71.31	$0.00	$71.31
12/20/13	G0151	$170.00	5	$11.41 x 125% = $14.26 x 5 = $71.31	$0.00	$71.31
12/22/13	G0151	$170.00	5	$11.41 x 125% = $14.26 x 5 = $71.31	$0.00	$71.31
12/23/13	G0151	$170.00	5	$11.41 x 125% = $14.26 x 5 = $71.31	$0.00	$71.31
12/24/13	G0154	$170.00	5	$98.92 x 125% = $123.65 x 5 = $618.25 however, 28 Texas Administrative Code §134.204 (d) states, "When there is no negotiated or contracted amount that complies with §413.011 of the Labor Code, reimbursement shall be the least of the: (1) MAR amount; (2) **health care provider's usual and customary charge,** unless directed by Division rule to bill a specific amount;"	$170.00	$170.00
12/24/13	G0151	$170.00	5	$11.41 x 125% = $14.26 x 5 = $71.31	$0.00	$71.31
		Total		$974.80	$170.00	$526.55

3. The total allowable for the services in dispute is $526.55. The carrier previously paid $170.00. The remaining balance is $356.55. This amount is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $356.55.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $356.55 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		March 25, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.